STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
	155694	B. WING		10/03/2012
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
BETZ NU	JRSING HOME	116 BE	TZ RD RN, IN 46706	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	BROWDEN'S N. AM OF CONDECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0000				
		170000		
	A Life Safety Code Recertification,	K0000		
	State Licensure and Quality			
	Assurance Walk-thru Survey were			
	conducted by the Indiana State			
	Department of Health in			
	accordance with 42 CFR 483.70(a).			
	Survey Date: 10/03/12			
	Facility Number: 000306			
	Provider Number: 155694			
	AIM Number: 100273860			
	Surveyor: Amy Kelley, Life Safety			
	Code Specialist			
	•			
	At this Life Safety Code survey,			
	Betz Nursing Home was found not			
	in compliance with Requirements			
	for Participation in			
	Medicare/Medicaid, 42 CFR			
	Subpart 483.70(a), Life Safety			
	from Fire and the 2000 edition of			
	the National Fire Protection			
	Association (NFPA) 101, Life Safety			
	Code (LSC), Chapter 19, Existing			
	Health Care Occupancies and 410			
	IAC 16.2.			
	IAC 10.2.			
	This one story facility was			
	determined to be of Type V (000)			
	construction and was fully			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000306

	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155694	B. WIN			10/03/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DET7 NI	JRSING HOME			116 BE	I Z RD N, IN 46706	
					11, 111 40700	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
1110		he facility has a fire	+	0		5.112
	·	•				
	alarm system v					
		e corridors, areas				
	· ·	rridors with battery				
	_ =	te detectors in the				
		The facility has a				
		and had a census				
	of 105 at the ti	ime of this survey.				
		<b>.</b>				
	The facility was					
	compliance wit					
	_	kler coverage and				
	smoke detecto	r coverage.				
	All areas where	e the residents have				
	customary acce	ess were				
		he facility had an				
	- ·	generator room and				
	-	oviding storage of				
	maintenance e					
	general storage					
	, gs. a. 3.3.4g	-				
	Quality Review by	Robert Booher, Life Safety				
	Code Specialist-Me	dical Surveyor on 10/05/12.				
	The facility was					
	compliance wit	th the				
	aforementione					
	requirements a	is evidenced by the				
	following:					

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Event ID: MZ9Q21

Facility ID: 000306

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STATEMENT O	F DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPLI	ETED
		155694	B. WINC		·	10/03/	2012
	l			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROV	VIDER OR SUPPLIER			116 BET			
BETZ NURS	SING HOME			AUBUR	N, IN 46706		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	īΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=E L D the state of the state	han required enclopenings, exits, or substantial doors, of 1% inch solid-becapable of resistin minutes. Doors in only required to resisting of the door with a means suitablesed. Dutch door with a means suitablesed. Dutch door mitted. 19.3.  Roller latches are regulations in all heased on obsernaterview, the farmatic ficient practices in the deficient practices in the which has a cape sidents.  Indings including ased on obsernaterview.  Indings including ased on obsernaterview.  Indings including ased on obsernaterview.  Indings including ased on obsernaterview.	corridor openings in other losures of vertical r hazardous areas are such as those constructed onded core wood, or ag fire for at least 20 a sprinklered buildings are esist the passage of no impediment to the rs. Doors are provided able for keeping the door for meeting 19.3.6.3.6 are 6.3  prohibited by CMS health care facilities. vation and acility failed to activity room in a set closed and a door frame. This ce could affect a Activity room of acity of 8  e:  vation with the	K00	18	It is the practice of this provide provide corridor doors that late into the door frame. What corrective action will be accomplished for those resider found to have been affected by the deficient practice? Latching hardware will be installed on the activity room door by Haney Glass. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Eight residents had the potential to be affected by the alleged deficient practice. The maintenance supervisor has contracted to he the latching hardware installed this one door in question. What measures will be put into place what systemic changes will you make to insure that the deficient practice does not recur? All future.	nts  / ne ner to ent  ave on e or u nt	11/02/2012

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Event ID: MZ9Q21

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  10/03/2012
		155694	B. WING		10/03/2012
	PROVIDER OR SUPPLIE URSING HOME	R	116 BE	ADDRESS, CITY, STATE, ZIP CODE ETZ RD RN, IN 46706	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	deadbolt the o	nt door. This was I by the Maintenance		renovations will be inspected to acceptance to insure that all corridor access doors have latching hardware. How will the corrective action be monitored ensure the deficient practice who trecur, i.e., what quality assurance program will be put into place? A Life Safety CQI to will be utilized to monitor compliance. The maintenance director will complete the tool the Executive Director will revito insure compliance. This tol will be submitted for review at monthly safety meeting if threshold is not achieved.	II e i to vill t ool e and iew I

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Event ID: MZ9Q21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155694			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  01	(X3) DATE S COMPL 10/03/	ETED
	ROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE TZ RD N, IN 46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0051 SS=E	installed accordin Fire Alarm Code, warning of fire in Activation of the cis by manual fire detection or extin Pull stations in pabe omitted provid stations are within stations. Pull stations are within stations. Pull station of egress. Electrotests are available of power is provid are maintained in and records of material available. There the fire alarm system of the fire alarm systation. 19.3.4, Based on observition interview, the fire resure 1 of 1 state 700 hall she entrance area wair flow would their operation requires in spatiandling system of be located prevents operated.	ices or equipment is g to NFPA 72, National to provide effective any part of the building. Complete fire alarm system alarm initiation, automatic guishing system operation. In a stient sleeping areas may ed that manual pull in 200 feet of nurse's tions are located in the path conic or written records of e. A reliable second source led. Fire alarm systems accordance with NFPA 72 anintenance are kept readily is remote annunciation of tem to an approved central 9.6 revation and facility failed to smoke detectors in lower room was installed where not adversely affect . NFPA 72, 2–3.5.1 ces served by air ms, detectors shall where air flow tion of the sideficient practice i residents in the	K00	051	It is the practice of this provide ensure that smoke detectors a installed where their operation not adversely affected by air flow. What corrective action wil accomplished for those reside found to have been adversely affected by the deficient practi. The maintenance supervisor contracted with IEI, Inc to move the smoke detector that was adversely affecting air flow in the 700 hallway. How will you idented to be affected by the same deficient practice and will corrective action will be taken fresidents have the potential to affected by the alleged deficient practice. The maintenance	is I be ints ce? e the tify nat 220 be	10/16/2012

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION  01	COM	E SURVEY PLETED
	155694	B. WING		10/0	3/2012
JRSING HOME		116 BE AUBUF	TZ RD	IP CODE	(45)
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE ()	(X5) COMPLETION DATE
Maintenance S 10/03/12 at 1 smoke detector entrance area was located with air supply ductor	upervisor on 2:40 p.m., the or in 700 hall to the shower room thin three feet of an t. This was by the Maintenance		move the smoke det was installed in the illocation. What measing put into place or what changes will you mathat the deficient pranot recur? All future in will be inspected pricacceptance to insure detectors are not place air flow will adversed operation. How will thaction be monitored deficient practice will i.e., what quality assigned program will be put illife safety review Coutilized to check place smoke detectors. The completed by the massing type in the safety committee for next monthly meetin executive Director is	tector that improper ures will be at systemic ake to insure actice does renovations or to e that smoke aced such that ly affect their he corrective to insure the II not recur, surance into place? A QI tool will be cement of his tool will be ainenance mitted to the review at the ag. The s responsible	
]	PROVIDER OR SUPPLIED  SUMMARY S  (EACH DEFICIEN REGULATORY OF  Based on an ol Maintenance S 10/03/12 at 1 smoke detector entrance area was located wire acknowledged Supervisor at toobservation.	DENTIFICATION NUMBER: 155694  PROVIDER OR SUPPLIER  JRSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Based on an observation with the Maintenance Supervisor on 10/03/12 at 12:40 p.m., the smoke detector in 700 hall entrance area to the shower room was located within three feet of an air supply duct. This was acknowledged by the Maintenance Supervisor at the time of observation.	OF CORRECTION IDENTIFICATION NUMBER: 155694  PROVIDER OR SUPPLIER  JRSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Based on an observation with the Maintenance Supervisor on 10/03/12 at 12:40 p.m., the smoke detector in 700 hall entrance area to the shower room was located within three feet of an air supply duct. This was acknowledged by the Maintenance Supervisor at the time of observation.	OF CORRECTION IDENTIFICATION NUMBER: 155694  PROVIDER OR SUPPLIER  JRSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Based on an observation with the Maintenance Supervisor on 10/03/12 at 12:40 p.m., the smoke detector in 700 hall entrance area to the shower room was located within three feet of an air supply duct. This was acknowledged by the Maintenance Supervisor at the time of observation.  3.1–19(b)  STREET ADDRESS, CITY, STATE, ZI 116 BETZ RD AUBURN, IN 46706  ID PROVIDERS PLANOF GEACH CORRECTIVE ACTR GROSS-REFERENCED TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCED TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCED TO TO DEFICIENCY  SUPPRISON THAN 16 STATE ACTR GROSS-REFERENCED TO TO DEFICIENCY  SUPPRISON THAN 16 STATE, ZI 116 BETZ RD AUBURN, IN 46706  ID PROVIDERS PLANOF GEACH CORRECTIVE ACTR GROSS-REFERENCED TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCE TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCED TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCE TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCE TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCE TO TO GEACH CROSS-REFERENCE TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCE TO TO GEACH CROSS-REFERENCE TO TO GEACH CORRECTIVE ACTR GROSS-REFERENCE TO TO GEACH TO GROSS-REFERENCE TO TO GROSS-REFERENCE TO TO GROSS-REFERENCE TO TO GEACH TO GROSS-REFERENCE TO TO GROSS-REFERENCE TO TO GRO	OF CORRECTION   IDENTIFICATION NUMBER:   155694

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	OF CORRECTION	IDENTIFICATION NUMBER:  155694	A. BUII	DING	01	COMPLETED 10/03/2012	
		133034	B. WIN			10/03/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BETZ NU	IRSING HOME		116 BETZ RD AUBURN, IN 46706				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0056	NFPA 101						
SS=E	LIFE SAFETY CC						
		matic sprinkler system, it is					
		dance with NFPA 13, nstallation of Sprinkler					
		de complete coverage for					
		building. The system is					
		ed in accordance with					
		rd for the Inspection,					
	_	itenance of Water-Based					
	Fire Protection Sy						
	•	e is a reliable, adequate he system. Required					
		are equipped with water					
		switches, which are					
	•	cted to the building fire					
	alarm system.	19.3.5					
	Based on obser	vation and	K00	56	It is the practice of this provide		11/02/2012
	interview, the f	acility failed to			ensure that sprinkler heads are		
	ensure 2 of 7 s	prinkler heads in			separated by at least 6 feet as required by NFPA 13.What		
		rridor and 4 of 4			corrective action will be		
	sprinkler heads				accomplished for those resider	nts	
	=	vere separated by at			found to have been affected by	/	
	least six feet as	required by NFPA			the deficient practice?The		
	13. NFPA 13 Se	-			maintenance supervisor contracted with PIPE, Inc to		
		lers be located no			properly position sprinkler hea	ds	
	-	feet measured on			in Therapy corridor and Activity		
					room kitchen area. 2 in the		
	center. This de				activity area were removed and	d	
		y resident in the			one in the hallway was repositioned to provide the pro	ner	
		or and the Activity			coverage. How will you identify		
		ith a capacity of 4			other residents having the		
	residents.				potential to be affected by the		
					same deficient practice and wh		
	Findings includ	e:			corrective action will be taken?		
					residents have the potential to affected by the one in the thera		
	Based on obser	vations with the			corridor and 8 residents have t		
	Maintenance Su				potential to be affected by the		
	ateriance st				<u> </u>		

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	01	(X3) DATE S COMPL	
11112 12111	or condition.	155694		LDING		10/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			116 BE			
	IRSING HOME				N, IN 46706		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	10/03/12 at 1	23 p.m. and then			the activity kitchen area. The		
	again at 2:12 p	o.m., the Therapy			maintenance supervisor contracted with PIPE, Inc to		
	hall had two sp	orinkler heads			properly position sprinkler hea	ds	
	located five foo	ot one inch apart			in order to give the	. 1	
		y room kitchen had			proper/required coverage.What measures will be put into place		
	•	neads located five			what systemic changes will yo	u	
	foot three inch				make to insure that the deficie practice does not recur?All fut	_	
		were provided by ce Supervisor at the			renovations will be inspected		
	time of observa				to acceptance to insure that		
	time of observe	ations.			sprinkler heads are separated at least 6 feet as required by	by	
	3.1-19(b)				NFPA 13. How will the correct	tive	
					action be monitored to ensure		
					deficient practice will not recui i.e., what quality assurance	,	
					program will be put into place	?A	
					life safety CQI tool will be implemented. The maintenant	`e	
					supervisor will complete the to		
					and present it to the safety		
					committee at the monthly meeting. The Executive Direction	tor	
					will be responsible to ensure		
					compliance.		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155694	B. WIN			10/03/	2012
	ROVIDER OR SUPPLIER		<u> </u>	116 BE	ADDRESS, CITY, STATE, ZIP CODE TZ RD RN, IN 46706	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0062 SS=E	continuously mair condition and are periodically. 19 NFPA 25, 9.7.5 Based on obser interview, the freplace 1 of 1 sthe upper cabir room and 1 of sprinkler heads loaded. LSC 9. automatic sprinbe inspected are accordance with Standard for the Testing, and M Water-Based Fi Systems. NFPA 2-2.1.1 requires shall be replaced corroded, dampet the improper of deficient practice residents in the which has a capresidents and compared to the same of the same	tic sprinkler systems are natained in reliable operating inspected and tested 1.7.6, 4.6.12, NFPA 13, revation and facility failed to sprinkler heads in net of the Activity 4 dish room 5 which were 7.5 requires all national national in h NFPA 25, e Inspection, aintenance of re Protection 1.25, 1998 edition, es any sprinkler ed which is painted, aged, loaded, or in rientation. This ce could affect e Activity room pacity of 8 dish room staff.	K00	062	It is the practice of this provider replace any painted, corroded damaged, loaded, or in the improper orientation sprinkler heads. What corrective action be accomplished for those residents found to have been affected by the deficient practice. The maintenance supervisor contracted PIPE, Inc to replace the 2 sprinkler heads found to have paint on them. How will yidentify other residents having potential to be affected by the deficient practice and what corrective action will be taken residents had the potential to be affected by the sprinkler head the activity area and the dietar staff had the potential to be affected by the sprinkler head found in the dish room area. The maintenance supervisor contracted PIPE, Inc to replace the 2 sprinkler heads that had paint on them. What measures be put into place or what syste changes will you make to insure that the deficient practice does not recur? All future renovation will be inspected prior to acceptance to insure that there are no sprinkler heads that ha inadvertantly gotten paint spraon them. The maintenance	will ce? e ou the ?8 be in ry The e s will emic re s s e ve	11/02/2012

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PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 155694  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  again at 2:25 p.m., there was a buildup of paint on the sprinkler head in the upper cabinet of the Activity room and the sprinkler head above the three  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Supervisor will be responsible to check those areas prior to completion of the revovation and discharge of the crew. How will the corrective action be monitored to insure the deficient practice will	
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  again at 2:25 p.m., there was a buildup of paint on the sprinkler head in the upper cabinet of the Activity room and the sprinkler head above the three	
BETZ NURSING HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  again at 2:25 p.m., there was a buildup of paint on the sprinkler head in the upper cabinet of the Activity room and the sprinkler head above the three  110 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  120 PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTIVE ACTION SHOULD BE (EACH CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  Supervisor will be responsible to check those areas prior to completion of the revovation and discharge of the crew. How will the corrective action be monitored to insure the deficient practice will	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  again at 2:25 p.m., there was a buildup of paint on the sprinkler head in the upper cabinet of the Activity room and the sprinkler  head above the three  ID PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG  PREFIX TAG  SUPERIX TAG  SUP	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  again at 2:25 p.m., there was a buildup of paint on the sprinkler head in the upper cabinet of the Activity room and the sprinkler head above the three  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  Supervisor will be responsible to check those areas prior to completion of the revovation and discharge of the crew. How will the corrective action be monitored to insure the deficient practice will	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG Supervisor will be responsible to check those areas prior to completion of the revovation and discharge of the crew. How will the corrective action be monitored to insure the deficient practice will	
buildup of paint on the sprinkler head in the upper cabinet of the Activity room and the sprinkler head above the three  check those areas prior to completion of the revovation and discharge of the crew. How will the corrective action be monitored to insure the deficient practice will	
compartment sink in the dish room. This was acknowledged by the Maintenance Supervisor at the time of observation.  3.1–19(b)  assurance program will be put into place? A life safety CQI tool will be utilized to check sprinkler heads for any paint overspray. The maintenance supervisor will completed the tool and submit it to the safety committee for review. The Executive Director will be responsible for insuring compliance.	3

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Facility ID: 000306

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED 10/03/2012	
		155694	B. WIN				
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			116 BE			
BET7 NU	RSING HOME				RN, IN 46706		
			_			1	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	DATE
K0069	NFPA 101	ESC IDENTIFIED IN ORDER TOTAL		1710			DATE
SS=D	LIFE SAFETY CO	DDE STANDARD					
00 2	Cooking facilities are protected in						
		9.2.3. 19.3.2.6, NFPA 96					
	Based on recor	d review and	K00	69	It is the practice of this provide	er to	11/02/2012
	interview, the f	acility failed to			ensure that kitchen exhause		
	ensure 2 of 2 k	itchen exhaust			systems are maintanned in		
	systems were r				proper working order.What corrective action will be		
	=	order. NFPA 96,			accomplished for those reside	nts	
		s inspection and			found to have been affected by		
		·			the deficient practice?360 deg		
	testing of the total operation and all safety interlocks in accordance with the manufacturer's				Services was contracted to ins	tall	
					Hinge kit and clean the inaccessible areas per their		
					9-25-12 report. Hinge kit had	to	
		all be performed by			be ordered and will be installed		
	qualified servic				soon as they receive itHow wil	I	
	minimum of or	nce every 6 months			you identify other residents		
	or more freque	ntly if required.			having the potential to be affect		
	This deficient p	oractice was not in a			by the deficient practice and w corrective action will be taken?		
	resident area b	ut could affect			residents were potentially		
	kitchen staff.				affected. Kitchen staff had		
					potential to be affected.		
	Findings includ	le:			Installation of hinge kit and		
	rmamgs merae	ic.			cleaning of exhaust system at that time correced the deficien		
	Pacad on racor	d review with the			practice.What measures will be		
					put into place or what systemic		
	Maintenance Su	•			changes will you make to insu		
		00 p.m., the 360			that the deficient practice does	5	
	Degree Service				not recur?All bi-annual		
	cleaning report				maintenace reports from 360 degree Services will be review	ed.	
	Report" dated (	09/25/12 stated			by the maintenance supervisor		
	"Customer has	a dish hood as			any additional items needing		
	well. Needs se	rviced at next visit.			attention. He will bring any iss	sues	
	Need extra tim	e on hinge kit			to the safety committed for		
		t. Duct has never			review.How will the corrective action be monitored to insure t	ho	
		r fans. Inaccessible			deficient practice will not recur	-	
			1				

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155694	A. BUILDING	01	COMPLETED 10/03/2012
		100084	B. WING	ADDRESS STATE OF THE STATE OF T	10/03/2012
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE	
	JRSING HOME		AUBUF	RN, IN 46706	_
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
	·			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR areas exist: far Cleaned all acceptable) exhaust system interview with	ns and ductwork. essible areas of n." Based on an the Maintenance he time of record have not been	TAG  TAG	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION DATE

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If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED	
155694		155694	B. WING			10/03/2012	
VIII OF D					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				116 BETZ RD			
BETZ NURSING HOME				AUBURN, IN 46706			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCE		DATE
K0147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD						
33-E	Electrical wiring and equipment is in						
		NFPA 70, National					
	Electrical Code. 9.1.2						
	Based on observation and		K0147		It is the practice of this provide	r to 10/19/2012	
	interview, the facility failed to				have electrical wiring and		
	ensure 2 of 2 power strips were				equipment in accordance with NFPA 70. What corrective action will be accomplished for those residents found to have been affected by the practice? Power strips that were not plugged directly into wall outlets were removed. How will you identify other residents having the		
	not used as a substitute for fixed						
	wiring to provide power from one						
	power strip to another. NFPA 70,						
	National Electrical Code, 1999						
	Edition, Article 400–8 requires,						
	unless specifically permitted,						
	•	and cables shall not			potential to be affected by the		
					deficient practice and what		
	be used as a substitute for fixed				corrective action will be taken?8 residents in the therapy area had the potential to be affected as well as the marketing staff(1		
	wiring of a structure. This						
	deficient practice could affect						
		e Therapy room			person). The removal of the		
	with a capacity of 8 residents and the Marketing office staff.				power strips(on 10-4-12) that		
					were not plugged directly into		
					wall outlet corrected the deficient practice. What measures will be		
	Findings includ	le:			put into place or what systemic		
					changes will you make to insu		
	Based on observations with the				that the deficient practice does		
	Maintenance Si	upervisor on			not recur?Management staff w		
		2:55 p.m. and then			educated about this practice a		
		o.m., there was a			morning meeting on 10-19-12 the maintenance supervisor ar		
		oplying power to			the executive director. All are		
	· ·				be checking for power strip us		
	· ·	strip supplying			on environmental rounds and		
		outer equipment in			customer care visits. How will t	-	
	_	office and in the			corrective action be monitored ensure the deficient practice w		
	Therapy room.				not recur, i.e., what quality		
	acknowledged by the Maintenance				assurance program will be put		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY							
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01		COMPLETED					
		155694	B. WING		10/03/2012				
NAME OF E	PROVIDER OR SUPPLIE	3	STREET .	ADDRESS, CITY, STATE, ZIP CODE					
				116 BETZ RD					
BETZ NU	JRSING HOME		AUBURN, IN 46706						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE				
TAG			TAG		DATE				
	Supervisor at the time of			into place?The mainenance	atria				
	observations.			supervisor will monitor power strip usage on the life safey CQI tool.					
				Tool will be discussed at safet					
	3.1-19(b)			meeting and CQI meeting.	<b>,</b>				

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